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Community Readiness for System of Care Change in the Mat-Su Region

Prepared by the Western Interstate Commission for Higher Education (WICHE) Mental Health Program
For: Department of Health and Social Services (DH&SS) in Alaska

EXECUTIVE SUMMARY

Alaska's Department of Health and Social Services (DH&SS) is currently undertaking the *Integrated Children Services Pilot Project*, which seeks to:

1. Develop and implement a two year project in the Matanuska-Susitna (Mat-Su) Borough to provide community-based, integrated wraparound social services to children and their families;
2. Develop a full array of services that meet or exceed specified quality assurance standards for these children and their families in collaboration with service providers and other state agencies;
3. Maximize the funding available for these services through collaborative planning with other entities that are funding social services in the region and minimize fiscal administrative tasks through the blending or braiding of funding provided by State and federal agencies to the greatest extent possible; and
4. Evaluate the outcome of the project with the goal of implementing successful elements of this project into a statewide behavioral services delivery system.

The effort to develop systems of care (please see page 7 for a more detailed description of systems of care-SOC) for children and families in the Mat-Su Borough is the first in what is anticipated to be a series of such efforts across the state. As one component of the this project, the Western Interstate Commission for Higher Education (WICHE) Mental Health Program conducted a community readiness assessment of stakeholders in this region. Community readiness evaluations identify specific characteristics related to different levels of problem awareness and readiness for change in a given community. This Executive Summary will present significant findings from the assessment, as well as offer recommendations.

Community Readiness Assessment Findings

- Overall, the Mat-Su region falls in the Preparation stage of community readiness, which involves active planning, a working group or committee of dedicated people, general information about local problems and efforts to solve them, a fairly active leadership, and the pursuit of resources to achieve goals.

- This is a dynamic time for both the State and the Mat-Su region. At the State level, the current process of integrating the Substance Abuse and Mental Health Divisions is not yet complete which has left many unanswered questions and a lack of full understanding by local provider agencies. The Mat-Su Region is currently experiencing massive growth in both population and industry, which complicates the ability to accurately assess and provide for community members' needs.

- There was unanimous and strong agreement among interviewees regarding the importance of creating integrated, comprehensive, child and family-focused, and community-based services.

- The Mat-Su region has a long history of both formal and informal collaborative programs or initiatives that address a wide range of problems faced by children and their families. The Mat-Su Area Partnership (MAP) group was identified by a majority of interviewees as among the most, if not the most, powerful collaboration in the region.

- Providers were described as significantly more aware of system of care services or efforts than families, although children and families who utilize services were reported to be much more aware than those who do not use services. Those in rural areas were described as particularly removed from and unaware of the system of care services or efforts.

- Strengths identified include successful collaborations that minimize competition and duplication, provide an array of services, and connect families to needed services. Providers are willing to work together and desire to help families and children, and are understanding of and empathetic toward families' needs.

- Weaknesses included administrative/political issues stemming largely from the integration of Substance Abuse and Mental Health Divisions. There is a sense that the process has not been transparent, which raises questions and suspicions. As a result, communication and coordination among agencies has waned and they are viewed as competing to monopolize decision-making and/or funding.

- Other weaknesses included very limited resources, such as time, money, and personnel generally or providers with specialized knowledge. Furthermore, limited services, waitlists, and turnover of personnel were considered major barriers.

- In terms of leadership, interviewees were able to name a number of individuals who have taken on leadership roles either in the past or recently. However, respondents indicated that instability at the state level and limited resources have compelled leaders to pull back from collaborative ventures and instead focus more on their own programs. Nevertheless, leaders were viewed as willing to support formal system of care development initiatives.

- Families who have direct experience with or require system of care services are more likely to support and participate in development initiatives than those who do not need or use these services.

- Primary obstacles to developing the system of care identified by respondents included fear and the lack of resources available for such initiatives. Fears center around the fact that there are limited resources (e.g., personnel, money) and the perception that the State will dictate how the project will be implemented without community input.

- There is no user-friendly, centralized resource for system of care services in the Mat-Su region. Additionally, there have been limited and ineffective outreach and educational efforts to increase the community's knowledge of existing services.

- Respondents indicated that with increased public education and awareness of system of care issues will come greater willingness to offer resources (e.g., time, space, people) to develop the system of care.

- Most community members turn first to family and friends for help when dealing with personal problems or crises, although some will utilize primary care providers, mental health service agencies, or school personnel.

- ❖ Respondents view the quality of services to be quite high, but limited staff and services result in a failure to meet the extensive and diverse needs of this rapidly growing community.

Recommendations

i. Due to the fact that recent changes in State government have created a sense of instability for agency Directors at the local level, Division Directors within the Department of Health and Social Services are strongly encouraged to:

   a. Present a unified message that supports the development of local systems of care and is buttressed with resources;
   b. Actively seek and incorporate community input during development procedures; and
   c. Engage in frequent and unambiguous communication with local child and family-serving agencies about state-level activities and progress.

ii. Utilize existing agency and organization collaborations in Mat-Su (e.g., MAP) to spearhead system of care development.

iii. Parents, family members, and youth consumers (of appropriate age) should be included in the development and implementation of system of care building strategies.

iv. Improve links to the rural communities and special populations (e.g., Alaska Natives, children with both physical and behavioral health problems).

v. Increase outreach and education to families. Outreach would raise awareness about existing programs and services, while education would inform the public at large about system of care issues, thereby achieving support from within and outside the traditional system of care.

vi. Create and implement a workforce initiative, which includes, but is not limited to, identifying who to recruit, levels of providers needed, and retention strategies.

vii. Further develop or create a Mat-Su directory of services that is more user-friendly and likely to be utilized.

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Introduction

Alaska's Department of Health and Social Services (DH&SS) has undertaken a project, called the *Integrated Children Services Project*, to improve systems of care for children and their families throughout the state. In a *Scoping Document* that outlines initial plans for the project, the authors state "The Alaskan service system for children with serious emotional disturbances, substance abuse problems, behavioral disorders or chemical dependence is fragmented. The services available vary dramatically from region to region and insufficient resources are available within the State of Alaska to meet the needs of these children and their families"[1] (p. 1).

The Scoping Document also provides details on the project goals and outcomes. Specifically, the Department of Health and Social Services (DH&SS) will:

A. Develop and implement a two year project in the Matanuska-Susitna Borough to provide community based, integrated wrap around social services to children who are:

   1. Ages 10 through 18 years of age, with a primary residence of the Matanuska-Susitna Borough and are seriously emotionally disturbed, or exhibiting behavioral disorders, or abusing substances or chemically dependent or exhibiting a combination of these disorders.

   Or

   Ages 10 through 20, if in addition to the conditions above they are developmentally disabled and still attending school.

   And

   2. Children who have been approved for out of state placement or are already in out of state placement and children and families receiving services from the Division of Behavioral Health and one or more of these three divisions, the Division of Public Assistance, the Office of Children's Services and the Division of Juvenile Justice.

B. Develop a full array of services that meet or exceed specified quality assurance standards for these children and their families in collaboration with service providers and other state agencies.

C. Maximize the funding available for these services through collaborative planning with other entities that are funding social services in the region and minimize fiscal administrative tasks through the blending or braiding of funding provided by State and federal agencies to the greatest extent possible.[2]

[1] Children and Youth Needs Assessment, October 2002, Alaska Comprehensive and Specialized Evaluation Services, University of Alaska, Anchorage, *page 40*.

[2] Blending funding: Funds are combined into a single pool from which they can be allocated to providers. Braided funding: Funds from various sources are used to pay for a service package for an individual child, but tracking and accountability for each pot of money is maintained at the administrative level.
Mix and Match Federal Programs to Support Interagency Systems of Care, A Bazelon Center Issue Brief. *page 4*.

D. Evaluate the outcome of the project with the goal of implementing successful elements of this project into a statewide behavioral services delivery system.

This report regards one component of the development of this project: community readiness for system of care change in the Mat-Su region. The assessment was conducted by the Western Interstate Commission for Higher Education (WICHE) Mental Health Program in March, 2005. This introduction will describe general issues related to systems of care for children and families, as well as the theoretical basis and implications of the community readiness assessment model. The report will then describe the community readiness assessments conducted with state agency officials and community members (providers and consumers) of the Mat-Su region, as well as offer recommendations based on evaluation results.

Systems of Care for Children and Families

Systems of care (SOC) for children and their families refer to the network of child and family-serving agencies, organizations, or institutions that exist within a given community. These include, but are not limited to, mental health and substance abuse services, juvenile justice, primary care, schools, social work, occupational therapy, physical therapy, and early learning or other educational programs. In essence, any individual or group, whether in the private or public practice, that offers some kind of service or program for children and their families is considered (in principle) a part of the system of care. However, this definition is not meant to minimize the significance or importance of other community members. All effective systems of care typically have strong links to other community members who are not traditionally or essentially focused on children or families.

Work on describing the core values and principles of an effective system of care began over 20 years ago. The core values of a SOC are:

1. It is child-centered and family-focused, with the needs of the child and family dictating the types and mix of services provided.
2. It is community-based, with the locus of services as well as decision-making responsibility resting at the community level.
3. It is culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

An implicit value that underlies those listed is that the particular form a system takes is specific to the locality in which it exists. That is, a good system of care is flexible and adaptable. On the other hand, community-specific does not mean isolated or fragmented. A good system of care is an integrated one. Thus, a challenge in developing local systems of care is to create goals and plans that enable flexibility in service provision that nevertheless maintain connections to the larger system of care and implement best or evidence-based practices. Toward this end, the system of care model identifies 10 guiding principles:

1. Access to a broad array of services that address physical, emotional, social, economic, employment and educational needs.
2. Individualized services based on unique needs of the child and family.
3. Services in the least restrictive, most normative environment that is clinically appropriate.
4. Families and surrogate families as full participants in all aspects of planning delivery of services.
5. Integrated services among child-serving agencies for planning, developing, and coordinating services.
6. Integrated and holistic case management to ensure coordinated and therapeutic services that address changing needs.
7. Early identification and intervention in order to enhance likelihood of positive outcomes.
8. Ensure smooth transition to adult services system as needed.
9. Protection of the child's rights, as well as advocacy efforts.
10. Service without regard to race, religion, national origin, sex, economic status or physical disability. Sensitivity and responsiveness to special needs.

Thus, taken together, the core values and guiding principles offer an overarching philosophical framework, as well as some concrete standards within which a given community develops its system of care. However, a particular system of care may look somewhat different from one community to the next, as determined by that community's available resources, abilities, and culture. One way to identify these aspects of a system of care is a Community Readiness Assessment.

Community Readiness

As developed by the Tri Ethnic Center for Prevention Research at Colorado State University, the Community Readiness Model is based on two theoretical traditions: 1) psychological readiness for treatment and 2) factors related to community development. Psychological readiness for treatment recognizes that clients have different levels of motivation to change and that effective therapy must acknowledge and align with the client. Community development recognizes that community activities involve complex, dynamic interactions and, therefore, focuses on group processes involved in decision-making. By combining these perspectives, community readiness identifies specific characteristics related to different levels of problem awareness and readiness for change in a given community.

The assessment also identifies particular resources and abilities in the community. Specifically, communities are evaluated in six dimensions, each of which is assigned a level of readiness along a continuum of nine stages. The six dimensions and nine stages are described in Tables 1 and 2 below.

Table 1: Dimensions of Community Readiness Assessment and Item Content

Dimension	Item Content
Existing Efforts	This dimension asks questions about: 1) The importance of creating integrated, comprehensive, child and family-focused, and community-based services; 2) Current services that are integrated/collaborative or efforts to create such services; and 3) The length of time the services or efforts have been going on.
Community Knowledge of Efforts	Items in this dimension ask about: 1) The extent to which both providers and consumers are aware of integrated services or efforts to create them; 2) Strengths and weaknesses of the services; 3) Segments of the population for whom services may appear inaccessible; 4) Planning for additional collaborations among services agencies; and 5) Efforts to integrate policies, procedures, or services across agencies.
Leadership	This dimension includes questions about: 1) Who the particular leaders are in the community regarding systems of care issues; 2) How important to the leadership is creating integrated, comprehensive, child and family-focused, and community-based services; 3) How leaders are involved in efforts to create such services; and 4) Whether the leadership would support efforts to develop the system of care.
Community Climate	This dimension asks about: 1) The community's attitude toward system of care services and related issues; 2) Willingness of the community to support or participate in system development; and 3) The primary obstacles to developing the system of care.
Community Knowledge of the Problem	Items in this dimension ask about: 1) How knowledgeable community members are regarding system of care issues; 2) The kinds of information available about services and how community members obtain it; and 3) Whether agencies are sharing data and using the data to develop the system of care.
Resources	This dimension includes questions about: 1) Who families and their children turn to for help first; 2) The level of expertise among those providing services; 3) Willingness of community members to offer resources such as personnel, money, time, and space to system of care activities; 4) Whether any funding proposals have been submitted regarding system of care development; and 5) Efforts to evaluate the system of care and whether or not the evaluation is being used to improve the system. 6) Tools, data and information systems, especially common elements.

Table 2: Nine Stages of Readiness

Stage	Description
No Knowledge	The issue/problem is not generally recognized by the community or the leaders as a problem. "It's just the way things are." Community climate may unknowingly encourage the behavior, although the behavior may be expected of one group and not another.
Denial	There is usually some recognition by at least some members of the community that the behavior itself is or can be a problem, but there is little or no recognition that this might be a *local* problem. If there is some idea that it is a local problem, there is a feeling that nothing needs to be or can be done locally. Community climate tends to match the attitudes of leaders and may be passive or guarded.
Vague Awareness	There is a general feeling among some in the community that there is a local problem and that something ought to be done, but there is no immediate motivation to do anything. Ideas about why the problem occurs and who has the problem tend to be stereotyped and/or vague. No identifiable leadership exists or leadership lacks energy or motivation for dealing with this problem. The community climate does not motivate leaders.
Preplanning	There is clear recognition on the part of at least some that there is a local problem and that something should be done about it. There are identifiable leaders, and there may even be a committee, but efforts are not focused or detailed. There is a discussion but no real planning of actions to address the problem. Community climate is beginning to acknowledge the necessity of dealing with the problem.
Preparation	Planning is going on and focuses on practical details. There is general information about local problems and needs as well as about the pros and cons of efforts, but it may not be based on formally collected data. Leadership is active and energetic. Decisions are being made about what will be done and who will do it. Resources are being actively sought or have been committed. Community climate offers modest support of the efforts.
Initiation	Enough information is available to justify efforts. An activity or action has been started and is underway, but it is still viewed as a new effort. Staff are in training or have just finished training. There may be great enthusiasm among the leaders because limitations and problems have not yet been experienced. Improved attitude in community climate is reflected by modest involvement of community members in the efforts.
Stabilization	One or two efforts or activities are running, supported by administrators or community decision makers. Programs, activities, or policies are viewed as stable. Staff are usually trained and experienced. There is little perceived need for change or expansion. Limitations may be known, but there is no in-depth evaluation of effectiveness nor is there a sense that any recognized limitations suggest a need for change. There may or may not be some form of routine tracing of prevalence. Community climate generally supports what is occurring.
Confirmation/ Expansion	There are standard efforts in place and authorities support expanding or improving efforts. Original efforts have been evaluated, modified and new efforts are being planned or tried in order to reach more people. Resources for new efforts are being sought or committed. Data are regularly obtained and efforts are made to assess risk factors and causes of the problem. Community climate may challenge specific efforts, but is fundamentally supportive.
Professionalization	Detailed and sophisticated knowledge of prevalence, risk factors, and causes of the problem exists. Some efforts may be aimed at general populations while others are targeted at specific risk factors and/or high risk groups. Highly trained staff are running programs or activities, leaders are supportive, and community involvement is

	high. Effective evaluation is used to test and modify programs or activities. Community members continue to hold efforts accountable for meeting community needs, but are fundamentally supportive.

Each of the six dimensions are scored from 1 – 9, indicating the level of readiness on each dimension. The average of these nine scores produces an overall score. The assessment uses key informants and a semi-structured interview methodology.

Based on community readiness scores, there are a number of recommended interventions related to each level of readiness a given community can utilize. In order to succeed, interventions introduced in a community must be consistent with the awareness of the problem and the level of readiness for change present among residents of that community. The table below indicates a number of interventions relevant to each stage of readiness, but it is noted that this list is not exhaustive of the possibilities for intervention.

Table 3: Stage of Readiness and Potential Interventions

Stage	Potential Interventions
No Knowledge	Raise awareness through one-on-one and/or small group activities, e.g., home visits, activity groups, talking circles, one-on-one phone calls.
Denial	Raise awareness using descriptive incidents, e.g., personalized case reports, critical incidents, media reports, presentations to community groups or similar educational interventions focused on local context. Statistics might not be that useful, except as an add-on.
Vague Awareness	Raise awareness through small group events, pot lucks, and newspaper editorials and articles. Local survey data, e.g., school or phone surveys, focus groups might be helpful.
Preplanning	Communities can begin to gather information related to effective programming, examine preexisting curricula and educational materials that are culturally relevant, make efforts to invest key people in the community planning process, conduct local focus groups or small public forums to discuss the issues, and increase media exposure.
Preparation	Gather and provide community-specific information to the general public and offer public forums for open discussion, e.g., reliable and valid survey regarding the issue(s), community attitudes/beliefs, in-depth local statistics, diverse focus groups, develop practical interventions.
Initiation	Similar to “Preparation” but includes training for professionals and/or paraprofessionals, consumer interviews to gain information on improving services and/or service gaps, identify potential funding sources to match community needs.
Stabilization	Initiating basic evaluation techniques to modify and improve services, provide in-service training to increase the number and quality of trained professionals, plan community events, offer community volunteer recognition, and conduct community workshops.
Confirmation/ Expansion	Similar but more sophisticated activities than previous stage, such as using external evaluation services to provide a more comprehensive community data base, initiation of activities that change local community policy/norms, media outreach that provides information about local programs and reports local data trends, and community focus groups and/or public forums to maintain grassroots involvement.
Professionalization	Very high level of data collection and analyses, sophisticated media tracking of trends, requesting local business sponsorship of community events, and diversifying funding resources.

Most community readiness evaluations regard a specific issue, such as prevention and treatment of methamphetamine abuse, keeping a school open, or any number of other examples. However, using community readiness to evaluate a system of care for children and families is somewhat more complex, as the focus of assessment includes multiple agencies, individuals, issues and opportunities. Nevertheless, the assessment is fairly easy to modify and apply to a whole system. The primary difference lies in the analysis of the data once gathered (results and analysis of the current evaluation are presented in a subsequent section).

Community Readiness Evaluation

Scott Adams, Psy.D., and Mimi Bradley, Psy.D., attempted to contact approximately 20 individuals—both providers of services and consumers—to schedule community readiness interviews, with the goal of completing between 10 to 15 interviews. Contact names were provided by Alaska state officials familiar with individuals in the Mat-Su region who are involved in the system of care. Face-to-face interviews were scheduled with 10 key informants, while three others were conducted via telephone, making a total of 13 completed interviews. In-person interviews were conducted in the Mat-Su region from March 9th to 11th, 2005. The telephone interviews were conducted the following week. In all, there were 10 providers or administrators of services and three parents of children who receive services. The range of agencies and experiences described by all key informants was comprehensive.

Results

Overall, the Mat-Su region falls in the Preparation stage of community readiness and opportunities. As briefly described earlier, the Preparation stage involves active planning, a working group or committee of dedicated people, general information about local problems and efforts to solve and implement them, a fairly active leadership, and the pursuit of resources to achieve goals. Specific issues regarding each of the six dimensions will be described in detail below, and each dimension will be rated on the same scale of readiness as the overall score. While some dimensions have higher scores than others, the aggregate of data indicates that the Mat-Su region is preparing to move their system of care for children and families forward.

Dimension A: Existing Efforts

The Mat-Su region falls into the Initiation stage of readiness regarding their existing efforts. This stage is more advanced than the Preparation stage, as it indicates that efforts are not only being planned, but also underway. There was unanimous and strong agreement among interviewees regarding the importance of creating integrated, comprehensive, child and family-focused, and community-based services. That is, all key informants strongly agreed with the core principles of a system of care.

At least 15 specific formal, collaborative programs or initiatives were identified as currently or recently (within the past 10 years) existing, with a number of other informal networks described. The range of agencies or organizations involved in these various collaborations spanned the system of care and address a wide range of problems faced by children and their families. However, these partnerships tend to involve 3-6 agencies and/or organizations, not the entirety of the system of care.

The Mat-Su Area Partnership (MAP) group was identified by a majority of interviewees as among the most, if not the most, powerful collaboration in the region. It was described as a catalyst for many of the specific formal and informal collaborations among the agencies who are a part of the MAP. The longevity of collaborations such as the MAP (somewhere between 15-20 years) suggests a solid history of agency willingness to work together.

Dimension B: Community Knowledge of Efforts

Scores on items regarding community knowledge of system of care efforts or services fell in the Preparation stage of readiness. However, there were some variations among the particular items. For instance, level of awareness of services or efforts was described as variable depending on one's relationship to the system of care and how long one has been connected to it. On the provider side, administrators were described as more likely to be aware of collaborations and the range of services than direct service clinicians, but both these groups were viewed as being far more aware than families as a whole (especially if administrators/providers have been in the system for at least five years). On the family side, those who receive services from system of care agencies were rated as more likely to know about the system than families who do not use the services. Again, the longer a family has had contact with the system, the more knowledgeable they were considered.

A number of strengths of the current system of care fall into the general categories of collaborations, attitude toward children and families, and specific resources or programs. Successful collaborations were reported to minimize competition and duplication, provide a heterogeneous mix of agencies and services, help stay current and aware of the variety of programs that exist and connect families to needed services, as well as identify and fill gaps in services. Providers were generally described as willing to work together and desire to help families and children, and are understanding of and empathetic toward families' needs. Specific resources and related programs identified as strengths were the Community Parent Resource Center and other family-centered agencies that offer training, advocacy, and services.

Most weaknesses identified in Mat-Su's current system of care fall under the categories of administrative/political, resources, and services. The basis of problems in the administrative/political arena was described as stemming from a lack of communication and coordination. Despite a solid history of positive and productive relationships among agencies, respondents indicated that collaboration tends to wax and wane, with the current period being one of waning collaboration. The integration of substance abuse and mental health was identified as one primary destabilizer and is viewed as resulting in competition to be "top dog" and monopolize decision-making. There is a sense that the process has not been transparent, which raises questions and suspicions. Those formerly involved in collaborative efforts are now

described as holding each other at “arm’s length” and controlling the flow of information. Participants at collaborative meetings were described as having their “hackles up” and using accusatory tones. Limits on information-sharing were also described as resulting from the use of different definitions of disability by different groups, or confidentiality issues.

Other impediments at the administrative level included a sense that some administrators do not necessarily support partnerships, that paperwork requirements are burdensome and may result in punishments if mistakes are made (e.g., Medicaid audits, the state may ask for money back), and that “forced” collaborations can lead to territorialism or other relationship problems.

Weaknesses in the area of resources were described as a lack of time, money, and personnel generally or providers with specialized knowledge (e.g., working with children who have both behavioral health and physical disabilities). Furthermore, turnover of personnel was considered a major weakness. Finally, a lack of community awareness regarding the system of care generally and children with special needs specifically was considered a problem, and outreach efforts have been lacking or ineffective.

Respondents indicated that accessing services is particularly difficult for several reasons. First, there reportedly are not enough services to meet the needs. Second, waitlists for services can be quite long and often result in clients not receiving help until their symptoms have become severe. Related to this issue, it was reported that there is a lack of follow through by providers, even regarding something such as getting a return phone call. Consumer respondents indicated having to make repeated phone calls to get a hold of providers. Finally, geographical distance, especially for those living in the outlying areas, was reported to be a major barrier to receiving treatment.

In terms of segments of the population for whom services may appear inaccessible, those in the outlying, rural areas were identified by many interviewees. Other groups include children with SED who do not have some type of coverage, children with traumatic brain injury, and those with special needs generally. Alaska Natives and a Russian population in the Mat-Su region were described as viewing services as inaccessible, as well as anyone who on a waitlist for services.

Most respondents indicated that there is relatively little planning about collaborative care at present. To the extent such planning is occurring, it involves a few agencies trying to address a particular problem, as opposed to system wide integration efforts.

Similarly, there were few efforts identified regarding integration of policies, procedures, or services across agencies. Some examples of the efforts that exist include the development of uniform assessment tools, one-stop shop at the Job Center, and the creation of a Borough Health Plan by the rural delivery network.

Consumers view current policies, procedures, or services as well-intentioned and sometimes effective, but faced with many challenges. The challenges include problems with recruitment and retention, a lack of qualified personnel, and significant turnover (which is reportedly true of all healthcare and other professionals, e.g., primary, teachers, occupational therapists, physical therapists, speech therapists, and so forth). Also, it was reported that if one is not aware of the

available services, not well-spoken or doesn't know what to ask for when pursuing treatment, the individual may not be treated well or referred to appropriate care.

Dimension C: Leadership

In terms of leadership, interviewees were able to name a number of individuals who have taken on leadership roles either in the past or recently. However, a significant number of respondents indicated that there appears to be a leadership void at present. Some indicated it is because previous leaders have left, retired, or have not continued in their roles. Others reported that political and/or programmatic changes have caused instability, which has made leaders hesitant to step forward and take on collaboration or other projects. Ongoing financial and resource difficulties have also required leaders to focus more on their own programs rather than take on new initiatives. However, respondents were unanimous in their report that leaders, to the extent they currently exist, strongly agree with the creating integrated, comprehensive, child and family-focused, and community-based services.

The primary means of creating such services on the part of leaders is to pursue funding (either individually or through inter-agency partnerships) and continuing to be a part of coalitions such as MAP, advisory councils, or specific multi-agency programs developed in previous years. Again, respondents view some agencies or organizations as more or less involved in such efforts, and the current political climate appears to be affecting the extent to which the aforementioned activities continue or are undertaken.

Most respondents indicated that leaders would be very likely to support further efforts to develop the system of care in the Mat-Su Borough. This support is, of course, within the context of the need for support at the state level, clear guidelines, input from the array of service providers and consumers, and a good plan. However, it was reported that there are some cultural and attitudinal barriers that may present obstacles to support system of care development. Generally, citizens in the Mat-Su region were described as being hesitant to change existing structures, suggesting that the public at large needs better information and greater awareness of the issues. To the extent that this cultural factor impacts leadership attitudes, it was believed that there is defeatism and a hesitancy to "step up to the plate." As a result, leaders are viewed as becoming overly protective of their own programs, to the point that innovation, collaboration, and expansion are inhibited.

Dimension D: Community Climate

Scores on items regarding the community's general attitude and willingness to support system of care development fell in the Preparation stage of readiness. Variability in responses regarded whether or not the family had personal experience with available system of care services in the community. Attitudes varied from vocal proponents of the system of care to apathy. Interviewees noted that families who do not have frequent contact with the mental health system, or who have come to expect marginal services, may portray an indifferent attitude toward the development of a system of care. Conversely, a family in need of system of care treatment for their child is more likely to support and participate in system of care development, as services are viewed as more relevant to their lives.

While some expressed the community's hesitance to support or participate in the development, the majority of the responses indicated that the more the community understands the meaning of a system of care, the more likely they will be willing to support the effort. An ongoing struggle in the Mat-Su area appears to be a lack of a concerted effort to launch an educational campaign targeting families. Several respondents explained a need to develop family-friendly outreach strategies so that families are informed of the range of services in their community and become more involved with these services. Interviewees noted the willingness of the community to participate in a needs assessment which indicates the possibility of supporting other similar projects.

The primary obstacles in developing the system of care fall into three main categories: 1) fear, 2) lack of resources, and 3) lack of leadership. Several respondents commented on people's fear that resources will dry up during the development of a system of care. This fear often creates territorialism which thwarts efforts to collaborate effectively. Another fear is based on the perception that the State of Alaska will dictate how to proceed with this project in the Mat-Su region without input from the community. Many interviewees expressed a belief that previous planning efforts are seldom followed up by any real action or measurable outcomes, thus, there remains some hesitance around such initiatives. There is some indication that lack of understanding regarding how to further develop the system of care fuels concerns. A second major barrier is the lack of resources, including a lack of ongoing funding and trained personnel to successfully carry out a large-scale system of care project. Lastly, although individuals in current leadership positions were identified and appear willing to participate, there is a concern that no one has taken the lead role in furthering the system of care in the Mat-Su region. Many attributed this lack of initiative to minimal available resources (i.e., time and money), as opposed to a lack of leadership capabilities.

Dimension E: Community Knowledge of the Problem

Items in this dimension inquire to what extent the community is aware of system of care issues. Results indicate the community falls between the Preplanning stage and the Preparation stage of readiness. This in-between stage of readiness suggests that the community may still be attempting to understand existing efforts and benefits of social service agencies in the Mat-Su region.

In general, responses indicated that the general community has limited knowledge of system of care issues unless they are directly affected by the need for specific services with the system of care. Typically, information about services is provided by word of mouth or by the initial agency contacted by the family. Most respondents noted that the information exists within each agency (i.e., agency pamphlets, etc.) but it is not readily available if you do not seek services within that organization.

There is no user-friendly, centralized resource for system of care services in the Mat-Su region. A web site providing general information on the Mat-Su region (www.matsuinfo.org) was created several years ago in an attempt to address this issue. However, the web site does not appear to be user-friendly (e.g., insufficient search function) when attempting to locate mental

health or other service agencies in the area. Many respondents noted that this web-site is used only infrequently if at all.

There is also a lack of available printed literature, advertising, or educational campaigns to help families determine what agency most appropriately meets their needs. The referral network tends to be informal, although there are a few more formalized, but scattered resources to help families find needed services. For instance, the Mat-Su Parents Resource Center (LINKS) maintains a list that helps refer families to services, but, it is unclear how often this resource is utilized. The Juvenile Assessment Center (JAC) also helps with referrals to service agencies. The JAC is a partnership between the Department of Juvenile Justice, the School District, and the police department to help triage children and adolescents in need of various services.

Most respondents indicated no knowledge of data sharing between agencies, but did refer to a needs assessment conducted several years ago by McDowell group under contract with MAP. The assessment represented a collaborative effort and the partners expect that the results may be useful in obtaining or informing systems of care funding in the future.

Dimension F: Resources

Results of items in this section pertaining to available resources and use of these resources fell in between the Preplanning Stage and the Preparation stage of readiness. Most respondents indicated that when families and their children are in need of help that they tend to turn first to other family members, friends, or neighbors (i.e., people they know and trust). Some respondents noted that families would generally turn to several of the larger mental health service agencies in the Mat-Su area for immediate assistance and for referral services. Interviewees also noted that it is not uncommon for children to turn to a school counselor or school nurse when they are in need of help. In addition, people may rely on their primary care doctor for referrals if they maintain a trusting working relationship. Unfortunately, law enforcement also tends to be a first responder to families in crisis, but this is not always by choice or preference of the family.

Overall, the level of expertise among those providing services to children and families was thought to be quite high. Although there has not been specific training on how to partner, most respondents indicated that the providers know the needs of the community.

Opinions on the willingness of community members to offer resources such as personnel, money, time, and space to system of care activities was somewhat mixed. In general, community members would most likely be willing to offer resources if they are well informed of the project and if they are included in the process from the beginning. However, they would be more willing to donate time, space, or materials (e.g., meeting space, copiers) than money. There was some indication that the community tends to be protective of its resources, while others noted that those more aware of system of care issues would be more willing to make contributions.

Respondents stated that there has not been a concerted, coordinated effort to apply for grant funding to develop a system of care. There have been some submissions for state funding by various agencies working collaboratively. However, most collaborative efforts have been limited to asking other agencies for letters of support on behalf of their individual agency projects.

Other than the aforementioned needs assessment there are no efforts to evaluate the current system of care. Most respondents referred to the needs assessment that the MAP uses to discuss collaborative efforts. Individual agencies used the results to fine tune their service delivery.

Summary

This is a dynamic time for both the State and the Mat-Su region. At the State level, the current process of integrating the Substance Abuse and Mental Health Divisions is not yet complete, which has left many unanswered questions and a lack of full understanding by local provider agencies. The Mat-Su Region is currently experiencing massive growth in both population and industry, which complicates the ability to accurately assess and provide for community members' needs. Nevertheless, there is a prevailing positive attitude toward system of care development at both the State and local levels.

Overall, the Mat-Su region falls in the Preparation stage of community readiness, which involves active planning, a working group or committee of dedicated people, general information about local problems and efforts to solve them, a fairly active leadership, and the pursuit of resources to achieve goals. There was unanimous and strong agreement among interviewees regarding the importance of creating integrated, comprehensive, child and family-focused, and community-based services. The Mat-Su region has a long history of both formal and informal collaborative programs or initiatives that address a wide range of problems faced by children and their families. The Mat-Su Area Partnership (MAP) group was identified by a majority of interviewees as among the most, if not the most, powerful collaboration in the region.

Providers were described as significantly more aware of system of care services or efforts than families, although children and families who utilize services were reported to be much more aware than those who do not use services. Those in rural areas were described as particularly removed from and unaware of the system of care services or efforts. Respondents view the quality of available services to be quite high, but limited staff and services result in a failure to meet the extensive and diverse needs of this rapidly growing community. Furthermore, there is no user-friendly, centralized resource for system of care services in the Mat-Su region. Additionally, there have been limited and ineffective outreach and educational efforts to increase the community's knowledge of existing services. Respondents indicated that with increased public education and awareness of system of care issues will come greater willingness to offer resources (e.g., time, space, people) to develop the system of care.

Strengths identified include successful collaborations that minimize competition and duplication, provide an array of services, and connect families to needed services. Providers are willing to work together and help families and children, and are understanding of and empathetic toward families' needs. Weaknesses included administrative/political issues stemming largely from the integration of Substance Abuse and Mental Health Divisions. There is a sense that the process has not been transparent, which raises questions and suspicions. As a result, communication and coordination among agencies has waned and they are viewed as competing to monopolize

decision-making and/or funding. Other weaknesses included very limited resources, such as time, money, and personnel generally or providers with specialized knowledge. Furthermore, limited services, waitlists, and turnover of personnel were considered major barriers.

Primary obstacles to developing the system of care identified by respondents included fear and the lack of resources available for such initiatives. Fears center around the fact that there are limited resources (e.g., personnel, money) and that the State will dictate how the project will be implemented without community input.

In terms of leadership, interviewees were able to name a number of individuals who have taken on leadership roles either in the past or recently. However, respondents indicated that instability at the state level and limited resources have compelled leaders to pull back from collaborative ventures and instead focus more on their own programs. Nevertheless, leaders were viewed as willing to support formal system of care development initiatives. Additionally, families who have direct experience with or require system of care services are more likely to support and participate in development initiatives than those who do not need or use these services.

Recommendations

i. Due to the fact that recent changes in State government, such as integration of Mental Health and Substance Abuse and reorganization as the Department of Health and Social Services, have created a sense of instability for agency Directors at the local level, Division Directors within the Department of Health and Social Services are strongly encouraged to:

    a. Present a unified message that supports the development of local systems of care and is buttressed with resources;
    b. Actively seek and incorporate community input during development procedures; and
    c. Engage in frequent and unambiguous communication with local child and family-serving agencies about state-level activities and progress.

ii. Utilize existing agency and organization collaborations in Mat-Su (e.g., MAP) to spearhead system of care development.

iii. Parents, family members, and youth consumers (of appropriate age) should be included in the development and implementation of system of care building strategies.

iv. Improve links to the rural communities and special populations (e.g., Alaska Natives, children with both physical and behavioral health problems).

v. Increase outreach and education to families. Outreach would raise awareness about existing programs and services, while education would inform the public at large about system of care issues, thereby achieving support from within and outside the traditional system of care.

vi. Create and implement a workforce initiative, which includes, but is not limited to, identifying who to recruit, levels of providers needed, and retention strategies.

vii. Further develop or create a Mat-Su directory of services that is more user-friendly and likely to be utilized.